MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

**Thursday, March 21, 2002**
**10:10 a.m.**

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
BEATRICE S. BRAUN, M.D.
AUTRY O.V. "PETE" DeBUSK
ALLEN FEEZOR
FLOYD D. LOOP, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
JANET G. NEWPORT
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

**AGENDA ITEM: Introduction: Assessing the Medicare benefit package -- Mae Thamer**

MR. HACKBARTH: I'd like to welcome our guests. As you know from our agenda, we will be spending today and tomorrow working on our June report on the Medicare benefit package.

As usual, we will have public comment period at the end of the morning and afternoon sessions each. As always, we'll ask you to keep your comments brief and to the point. I know that sometimes we have multiple people representing a particular point of view. I will ask you to listen to the comments that went before you and, if you don't have anything new to add, please exercise restraint because we do have a number of people who want to get to the microphone and offer their comments.

The first discussion will be led by Mae on the introduction to a report on assessing the Medicare benefit package.

* DR. THAMER: In the next two days, you will be hearing many presentations that are related to the June report. In my introductory presentation here, I'd like to give you a general sense of what you will be hearing, how the presentations are related to one another, and to the objectives of the June report, and basically the general direction that we're embarking on.

To quickly review, the three objectives of the June 2002 MedPAC report are to identify the major changes that have occurred since the creation of the Medicare program and the original design of the benefit package, to assess their implications for Medicare beneficiaries, and the adequacy of the Medicare benefit package, and to examine the various options to modify the current benefit package to possibly better meet the needs of the Medicare beneficiaries.

First, I will review the major findings related to three topics that were presented earlier to the Commission. These topics include the changing beneficiary profile, chronic conditions and care, and the use of preventive and primary care services. The purpose of revisiting these earlier presentations is that we would like the commissioners to keep these issues and findings in mind when they hear the subsequent presentations today and tomorrow.

After I review this earlier data, I will introduce the new

topics that will be presented to the Commission the remainder of today and tomorrow.

In January, we presented a discussion on the changing beneficiary profile from 1965 until the present. I'd like to highlight the most salient findings. First of all, in terms of demographics, the elderly population is increasing in numbers with the greatest increase in the proportion of persons that are age 85 and older. This is reflected in Medicare's enrollment, which has increased from 19 million in 1966 to 40 million in the year 2000. The number of disabled has also increased from 1.7 million in 1973, when the benefit was first enacted, to 5.2 million in the year 2000.

Secondly, in terms of informal social support, it's increasingly limited as the elderly age. Half of all women over age 75 live alone in the year 2000. Unfortunately, there's no comparable data from the '60s or '70s to verify whether social support has been eroding among the elderly during this time or not.

For men of age 65, life expectancy has increased from 13 years in 1966 to 16 years in 2000, an increase of three years. And for women at age 65, life expectancy has increased from 16 years in 1966 to 19 years in 2000, also an increase of three years.

The percent of elderly living below the poverty line has decreased from 29 percent in 1966 to 10 percent in the year 2000. The proportion of income spent on health care is an interesting statistic. That's remained the same, at approximately 20 percent in 1966 and 2000, although it initially decreased to 11 percent after Medicare was first enacted and has slowly risen back up.

Another presentation in January with important implications for the June report that I'd like to review, addressed chronic conditions and their care. There were three important findings that I'd like to reiterate at this point. One is that chronic conditions among the elderly are highly prevalent, including multiple conditions. Depending on the study prevalence rates for chronic conditions have been cited as anywhere from 70 to 90 percent of all elderly.

Number two, effective care has been demonstrated and includes the following elements: interdisciplinary team assessment, early detection of functional impairments, evidence-based treatments, patient self-management, appropriate use of

medications, and assistive devices for mobility, hearing and vision.

The third point is that Medicare's ability to promote quality chronic care is currently limited because number one, Medicare doesn't cover or provides limited coverage for certain services that are required such as prescription drugs, case or disease management, and other coordination of care activities.

Secondly, fee-for-service Medicare does not generally promote coordination and continuity of care, since there's no financial incentives to provide such care.

And third, providers are not reimbursed for providing instructions on behavioral change or self-care, or addressing emotional or psychological needs of patients.

The last presentation I'd like to review is preventive services. In 1965 preventive services were not covered as part of the Medicare benefit package, but they've been added based on Congressional approval on an ad hoc basis in subsequent years. Medicare covers some of the preventive services that have been recommended by the U.S. Preventive Task Force for the Elderly, such as flu and pneumococcal vaccines and the pap smear, but not others, such as smoking cessation and diet and exercise counseling. Also, Medicare covers preventive services that aren't recommended by the task force, such as bone density screening and PSA.

Compared to private plans, Medicare's coverage of preventive services is similar with the exception that private plans cover annual physical exams and selected counseling.

Finally, I want to say that coverage of preventive services is only one determinant of their use. Other determinants include the extent of cost-sharing, physician recommendation, patient education and outreach efforts.

Today and tomorrow we'd like to present additional evidence to the Commission to allow you to better assess the Medicare benefit package. The new topics that we're going to present include the results of an expert panel of geriatricians, historians, public health experts, managed care providers, bioethicists, technology experts and others regarding the changes in the medical practice and delivery of care since 1965, and its implications for the current Medicare benefit package.

Second, we're going to have a guest lecturer that's going to

present the results of an analysis of changing in the private sector benefit packages, including a discussion of the relevance of private sector benefit packages in serving as a role model for the Medicare benefit package.

Third, we're going to have another guest lecturer, along with MedPAC staff, that will present the trends in beneficiaries' supplementation of the Medicare benefit package, including a discussion of the stability of retiree health plans, the availability and cost of Medigap coverage, the availability and underuse of Medicaid benefits, and the changing nature of the benefits offered by M+C plans.

Finally, MedPAC staff will discuss why beneficiaries' out-of-pocket spending is a concern and we'll present data showing the proportion of income that's spent on health care, as well as show you that high out-of-pocket spending often persists for years among certain beneficiaries.

Second, MedPAC staff will present estimates of the total pool of funds that are spent on beneficiaries for all services, with the exception of long-term care. And we're going to show you breakdowns by sources of funds, the amount that's covered by Medicare as well as other payers and what's purchased with this.

Finally, in tomorrow's presentations, we plan to discuss three topics that will give you the general direction, as well as the analytical framework, for the June report. First, we're going to have preliminary findings of what we anticipate to be the most significant, cross-cutting findings, and their policy implications.

Second, I will introduce the criteria to both evaluate the current benefit package as well as to evaluate new proposals. The criteria are necessary to understand the values and trade-offs in various approaches to changing the benefit package.

Last, we're going to presenting a variety of illustrative options on how to address the inadequacies and limitations of the benefit package. We've modeled several of these options to give the commissioners an idea of the cost implications inherent in various proposals to modify the benefit package.

MR. HACKBARTH: Any quick questions for Mae?

MR. FEEZOR: Not so much quick questions, but as we think about our report, there are a couple of things that I made note of as I was coming in that I guess I'd just like to throw out for

our thinking.

The first is to make sure if we're using some of the normal benchmarks that they make sense, or are we simply captured by how we have always categorized things? For example, the over-85/under-85. Are there reasons we use 85 as a benchmark? Particularly with large loads of people coming into the system, it may be breaking it up makes it different. That's sort of one way of looking at it.

The issue of disabled, we probably need to spend a little more time in terms of the disabled versus maybe severely disabled and recognize there are some significant differences in consumption and needs that might come about.

The life expectancy, by itself, is helpful to know in terms of quantifying things, but some qualitative measures and what that may mean that are associated with that may be, in fact, more revealing in terms of the resource consumption that that longevity factor does.

Then the issues like you talk about the average income. Throughout the report there's some reference back and forth in terms of disposable income may be, in fact, a helpful measure.

I guess what I'm saying is instead of picking up what is always assumed, that we've got to do some rethinking. Going back to the first benchmark of the 85 as sort of being one of the clear lines of break, and I'll come back to this a little later as we start thinking about some options, it very well may be that 85, 82, 75 or 15 years in or whatever, that there is a significant change in consumption patterns and it very well may be that one of the social policy choices that we may want to put up is that, in fact, Medicare have a stage level of benefits, that in fact there is a different set of services that are available as one progresses through that. Just conceptually.

So anyway, those are just some thoughts to rethink, and part of it is dealing with my responsibilities for the under and over-65, we're having to really do some rethinking. And I found that many of the ways we've categorized our statistics sort of helped guide us to some of those same old conclusions. So that's a note of caution for all of us, as well as for staff, in terms of when we start grinding through those numbers.

DR. NELSON: Mae, I had a question with respect to the Medicare Coverage Advisory Commission and whether it is looking

at the benefit package in a global sense, as we intend to approach our task, or whether it's looking just at specific new technologies that are presented to it a few at a time?

So I guess what I'm asking is whether or not they are proceeding on a parallel path or whether they're much more isolated?

DR. THAMER: I'm sorry, are you referring to the expert panel that we had?

DR. NELSON: Medicare Coverage Advisory Commission.

DR. THAMER: They tend to look at new technologies, I think, in general. New technologies that are coming, not the whole program. That's my understanding.

MS. JENSEN: They evaluate coverage for services that would already be covered under the broad guidelines of the current benefits package, specific procedures, specific -- they would be things that would already be covered broadly.

MR. MULLER: Since we know that a lot of the costs of any of these populations are in the very highly acute or catastrophic or end-of-life cases -- I don't mean to use those as determinants terms -- do we have any estimates or can we derive any estimates as to if the benefit package changed, what kind of effect that might have on our ability to avoid some of those cases?

I know that in the common criticism of insurance systems, at least the U.S. insurance system, is that in the under-65 population, there's no incentive to take care of people in the long term, because by the time the benefit accrues to you, they're in some other insurance plan.

In the Medicare population, there's at least an argument that you have these people for 16, 19, 20-some years, and therefore the virtue of putting together a set of services that could, at the margin at least, avoid some of those highly acute costs. That might be beneficial to the overall system.

Are we likely, or is it possible to make those kind of estimates in this time frame, this period, as to if one had a different benefit package that might have some effect on avoiding some of these heavy costs at acute and end-of-life stages?

DR. THAMER: That's an excellent question. We have not done that kind of modeling yet, although we possibly can. You'll see, tomorrow, the models that we've done. But they haven't, to my

knowledge, looked at avoiding end-of-life costs or even avoiding acute exacerbations of chronic conditions or costly outcomes. We haven't modeled that, but that's certainly an excellent idea. Of course, the modeling is a little bit more complex, but maybe we can build that in.

MR. MULLER: That would be one of the policy justifications for looking at that. I know most people feel that no matter what service you have, every one is additive rather than in some ways complementary. If we can't do it in the next three months, I think looking at that time frame may be something we look at in the long term.

MR. HACKBARTH: Thanks Mae.